STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 92791-001**

v

Golden Rule Insurance Company
Respondent
_____/

Issued and entered
this 20th day of November 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 22, 2008, XXXXX ("Petitioner") filed a request for external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner of Financial and Insurance Regulation accepted the request on August 29, 2008. The Commissioner notified Golden Rule of the external review and requested the information used in making its adverse determination.

The case presented a medical question so the Commissioner assigned it to an independent review organization, which provided its analysis to the Commissioner on September 15, 2008.

II
BACKGROUND

The Petitioner receives health care benefits under an individual policy underwritten by Golden Rule Insurance Company.

The Petitioner received treatment at the XXXXX from November 12 to 19, 2007. This included lumbar back surgery that cost $30,000 and cervical surgery that cost $25,000. Golden Rule denied coverage for this care because it concluded the care was not medically necessary.

The Petitioner appealed Golden Rule's decision. Golden Rule reviewed the claim but upheld its decision. The Petitioner exhausted Golden Rule's internal grievance process and received a final adverse determination dated July 8, 2008.

III
ISSUE

Did Golden Rule correctly deny coverage for the care provided the Petitioner at the XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner argues that he contacted Golden Rule prior to his back surgery to make sure it was covered under his policy. In addition, he says his wife was assured on several occasions that it would be paid. The Petitioner had to prepay $55,000 for his surgeries at the XXXXX.

The Petitioner had the surgeries on November 14, 2007 and November 19, 2007. Golden Rule has failed to pay for this care. The Petitioner argues that these surgeries were medically necessary and therefore covered under his policy. He wants Golden Rule to pay for this care since it is a covered benefit and Golden Rule indicated prior to this care that it was a covered benefit.

Respondent's Argument

It is Golden Rule's position that the Petitioner's care at the XXXXX is not a covered benefit since it was not medically necessary. In its final adverse determination, Golden Rule cites the provision in the Petitioner's policy regarding the definition of medical necessity:

> Medically necessary means a treatment, test, procedure or confinement that is necessary and appropriate for the diagnosis or treatment of an illness or injury. This determination will be made by us based on our consultation with an appropriate medical professional. A treatment, test, procedure or confinement will not be considered medically necessary if:
>
> (A) It is provided only as a convenience to the covered person or provider;
>
> (B) It is not appropriate for the covered person's diagnosis or symptoms or;
>
> (C) It exceeds (in scope, duration, or intensity) that level of care which is needed to provide safe, adequate, and

> appropriate diagnosis or treatment to the covered person.

The General Exclusions and Limitations section of the policy states:

> Even if not specifically excluded by the policy, no benefit will be paid for a service or supply unless it is . . . medically necessary to the diagnosis or treatment of an injury or illness.

Golden Rule says it sent the Petitioner's medical records to an outside reviewer who determined that the services in question were not medically necessary because there were no objective signs of radiculopathy and there was no documentation indicating that a pre-operative examination was performed or any form of conservative treatment administered prior to surgery.

Commissioner's Review

Because this case involved medical issues, the Commissioner referred it to an independent review organization ("IRO") for analysis. The IRO reviewer is a physician in active practice who is certified by the American Board of Orthopedics. The reviewer is a member of the American Academy of Orthopedic Surgeons, the American Medical Society, and the Eastern Orthopedic Association. The IRO reviewer concluded that medical necessity has not been established for the Petitioner's lumbar surgery on November 14, 2007, and his cervical surgery on November 19, 2007.

The IRO physician concluded that the Petitioner's surgeries were not appropriate for the Petitioner's diagnosis or symptoms and they exceeded – in scope, duration, and intensity – the level of care which was needed.

The IRO physician also concluded there was no objective evidence to support the above procedures according to the Petitioner's physical exam and clinical presentation. There was nothing to explain his miraculous recovery, especially as regards to urinary and sexual sensitivity problems or the bilateral numbness in his arms and legs.

The Commissioner is not required in all instances to accept the IRO expert's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the commissioner did not follow the assigned independent review

organization's recommendation." MCL 550.1911(16) (b). The IRO's analysis is based on extensive experience, expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the conclusion of the IRO that the services the Petitioner received from November 12 to November 19, 2007 at the XXXXX were not medically necessary and therefore, not a covered benefit.

Finally, the Petitioner believes that Golden Rule indicated to him that his November 2007 back surgeries would be a covered benefit. Under the PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of the factual dispute described by Petitioner cannot be part of a PRIRA decision because the PRIRA review process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds Golden Rule correctly applied the provisions of the Petitioner's policy of coverage when it denied coverage for his care from November 12 to November 19, 2007 at the XXXXX.

IV
ORDER

The Commissioner upholds Golden Rule's adverse determination of July 8, 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, P. O. Box 30220, Lansing, MI 48909-7720.